INDUSTRIAL DEMOCRACY
• PERIODICAL STUDIES IN ECONOMICS AND POLITICS •

# *Health Security for the Nation*

By JOHN A. KINGSBURY, LL.D.

*Former Director, Milbank Memorial Fund*

*Associate Fellow, New York Academy of Medicine*

VOLUME VI NUMBER 3 OCTOBER 15, 1938

THE LEAGUE FOR INDUSTRIAL DEMOCRACY is a membership society engaged in education toward a social order based on production for use and not for profit. To this end the League conducts research, lecture and information service, suggests practical plans for increasing social control, organizes city chapters, publishes books and pamphlets on problems of industrial democracy, and sponsors conferences, forums, luncheon discussions and radio talks in leading cities where it has chapters.



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# *Health Security for the Nation*

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*"Civilized communities have arrived at two conclusions, from which there will be no retreat, though their full realization in experience has nowhere been completely achieved.*

*"In the first place, the health of every individual is a social concern and responsibility; and secondly as following from this, medical care in its widest sense for every individual is an essential condition of maximum efficiency and happiness in a civilized community."*

—SIR ARTHUR NEWSHOLME (Medicine and the State)

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# INTRODUCTION

If the question were asked of one hundred average men and women, "What do you treasure most in life?" my guess is that a large proportion of that one hundred people would reply, "Good health."

The American people are becoming increasingly health conscious. They are likewise coming to an ever greater extent to realize that, if the 130,000,000 people in the country are to enjoy the maximum amount of good health, if they are to obtain adequate treatment when they are sick, society must regard health as a public, not a mere private problem.

Many of the thinkers and doers in America have been recognizing this fact for years past. One of these is John A. Kingsbury. Mr. Kingsbury came in vital touch with problems of health among the workers of America over a generation ago. During the last twenty odd years, as member of the Governor's Public Health Commission, General Director of the Association for Improving the Condition of the Poor, Commissioner of Public Charities of New York City, Secretary of the Milbank Memorial Fund, an active spirit in many other social service organizations, and as a careful student of health agencies in Europe, he has grappled as few men have with the question of how the community can best improve the national health. His *Survey* article on "Mutualizing Medical Costs" and his paper on "Adequate Health Service for All of the People," delivered at the 1934 meeting of the National Conference of Social Work, the fruits of

many years of pioneering, thinking and activity, attracted wide attention for their comprehensive grasp of this problem.

In 1937, Mr. Kingsbury delivered before the National Conference a brilliant paper on "Health Insurance in a National Health Program" which was later awarded the 1937 Pugsley Award for the outstanding contribution to that gathering.

The League for Industrial Democracy has been fortunate indeed in securing Mr. Kingsbury as an author in its pamphlet series on the problem of public health. Mr. Kingsbury, in preparing this pamphlet, has utilized some of the material contained in his National Conference contributions and has brought it up-to-date. In the latter tasks, he has been ably assisted by a number of Washington experts.

We present this pamphlet as one of the most significant of this year's series.

HARRY W. LAIDLER

# *Health Security for the Nation*

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STATESMEN from Disraeli to Roosevelt have said that the health of the people is a paramount duty of the state. Said Disraeli, "The public health is the foundation upon which rests the happiness of the people and the welfare of the state." President Roosevelt has put it even more effectively in his statement that "Success or failure of any government in the final analysis must be measured by the wellbeing of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people."

Surely no intelligent person today would challenge these statements. Yet, with the single exception of the Soviet Union, no modern state has seriously undertaken to translate that fundamental proposition into effective government policy in time of peace. Only in time of war, or when there is threat of war, does the health of the citizens become a matter of great official concern. The present excitement in Great Britain over the neglected health of youths and adults illustrates the point. Is the need for cannon fodder the only cause of sufficient weight to precipitate a national pursuit of health? Must we in the United States wait on military needs to stimulate a health program? Or can we hope to embark on a health program in time of peace and for the peaceful purpose of encouraging the pursuit of happiness? I, for one, believe that health service is deserving of our most statesmanlike effort, in time of peace, in the search for a kindlier and a better way of life.

The health of our people is our greatest wealth, and what is true in this regard of the nation as a whole is true of the family and of the individual. It is self-evident that, without physical and mental health, freedom has but limited meaning, and the pursuit of happiness becomes but the shadow of its own substance.

A National Health Conference was held in Washington on July 18-20, 1938, at the suggestion of President Roosevelt and at the call of the Interdepartmental Committee to Coordinate Health and Welfare Activities.* It brought together nearly two hundred delegates representing industry, labor, farmers, agricultural workers, welfare groups, civic clubs, government administrators, public health officers, doctors, dentists, nurses, hospital directors, social workers, the press, the radio, magazine editors, and many others. In addition, there were about two hundred "observers," representing many other portions of the nation. The conference members had been called together to receive the report of the Technical Committee on Medical Care, a subcommittee of the President's Interdepartmental Committee, which presented the nation's health and sickness needs, and outlined a national health program to deal with them. The unmet needs, the Committee showed, are enormous; the unnecessary distress, suffering, sickness, crippling, premature death, dependency, and social waste are appalling. These preventable needs cost us billions of dollars every year—to say nothing of the incalculable suffering and misery. Is all this necessary? Is it unavoidable?

In carefully measured words, calmly and firmly, the Technical Committee said: "No." It outlined a program of action to deal with the situation. The Interdepartmental Committee also said: "No," clearly and courageously, and asked the conference what it thought about the situation. The conference members—not unanimously but overwhelmingly—also said: "No." They said this loudly, strongly, over and over again, and gave their reasons from their experiences. They said: "Let's get on with the job." And they said this in answer to the challenge which the government of the United States presented to them when the Chairman, Miss Josephine Roche, made clear that you could not tackle a ten billion dollar sickness problem with small change.

Spokesmen for all the important sections of the American people asked for an end of research, surveys, and fact finding; they called for action—*now*. They were not frightened by the costs which their groups would have to meet if the people of this country are to have

* This committee had been created in August, 1935, and includes Miss Josephine Roche, formerly Assistant Secretary of the Treasury, the Assistant Secretaries of Agriculture, Interior and Labor, and the Chairman of the Social Security Board.

an opportunity for health. They knew only too well the far greater costs which are paid as the price of sickness.

The only objections to the government's program came from a few spokesmen of medical politicians who control the American Medical Association. When the opportunity was given them to challenge the basic facts of unmet needs, of unattended sickness, of unnecessary suffering, of preventable deaths, they spoke no word. At the close of the first day's session the following question was put to the assembled delegates: "Are there any members of this Conference who challenge the statements with reference to needs which were made this morning?" There was a long and ominous pause. Obviously everyone expected the spokesmen of the American Medical Association to repeat their oft-reiterated reckless challenge of the findings from the studies of the Committee on Costs of Medical Care (1927-1932), of the Committee on Economic Security (1934-1935), and of any other agency whatsoever, not sponsored, authorized or controlled by organized medicine—and there was nought but silence on the part of the usually bold critics now publicly faced by experts thrice armed with results of years of painstaking research. The chairman repeated the question, and again paused for reply. He might have added, "Then none have I offended." Instead—and more wisely—he said: "Then this is a fitting note upon which to close the first day's session. The conference is adjourned until tomorrow morning at 9:30."

But when the program of action was laid before them the following day, the representatives of the American Medical Association flashed a red light, and talked about going slowly and waiting for the results of the inquiry which *they* had instituted among members of the medical profession. They talked about unemployment, old-age, freedom, regimentation, and other subjects on which they had no special or expert knowledge and which had nothing to do with the subject under discussion by the conference. Do nothing, and do it carefully for a long time, was their wisest counsel; leave everything to the American Medical Association, and all problems will be solved.

Be it said to the credit of the American medical profession that there were physicians at the conference, distinguished for their attainments in medicine, surgery, and other special fields of medicine, rather than for accomplishments in medical politics, who spoke cour-

ageously and forthrightly in support of the objectives of a national health program, whether or not they agreed with all the details of the government's program. One must distinguish carefully between the medical profession and the political hierarchy of medical politicians who live contented lives on their large salaries or rich private practice.

The National Health conference was a landmark in America's search for health, happiness, and security.

The development of a sound national health program is greatly nearer attainment since the Conference showed a clear-cut demand for action by the public. Furthermore, the overwhelming public sentiment forced the American Medical Association to call a special meeting of its House of Delegates (September 16, 1938) to discuss the program presented at the Conference. At that meeting, the Association gave substantial endorsement to the program developed by the President's Interdepartmental Committee. The time has passed when only a small group of progressive leaders and research workers studied the nation's needs and proposed general programs to meet these needs. The time has come when the nation undertakes the job of equipping itself with health services appropriate, in scope and content, to the ability of the professions to serve the public and proportionate to our national ability to support the services we want and can have.

Today health service means vastly more than the services of the physician. It embraces specialists of many kinds—dentists, hospital staffs, medical and other social workers, nurses, pharmacists, X-ray operators, bacteriologists, chemists, physicists, and a host of other workers, skilled and unskilled. It includes health officers, visiting nurses, experts on health education, sanitary engineers, statisticians, and many more who are skilled in the prevention of disease and in the solution of social problems created by sickness. Medicine and medical care in the United States engage the labor of over a million people. Our hospitals alone represent a capital investment of over three billion dollars. The physician is still the center of this immense personnel and machinery, but medicine is now vastly more than the service of the physician.

The enormous growth in medical knowledge and the vast increase

in the complexity of medical art have brought complications which no one foresaw and which no one fully understands. The arrangements under which our medical personnel and facilities serve the public have been undergoing rapid changes. Widespread public discontent testifies that these arrangements are still far short of perfection. There is room for improvement in the relations of medicine to society and in its adjustment to the changing needs of the times.

When I speak of public discontent, I refer to the arrangements under which medicine serves the public; I do not refer to the scientific or practical workings of medicine itself. To be sure, there is room for improvement in the skill of many practitioners, in the administration of hospitals, clinics, and laboratories. But, generally speaking, the world is familiar with the great advances which have been made in the medical sciences and takes pride in the unselfish and faithful devotion with which scientific progress has been given practical application. The science and the art of medicine are certainly traveling forward and on a high road, and the discriminating public has the highest confidence in the future of medical practice.

Public confidence in the technical affairs of medical practice is one thing; the public attitude toward the arrangements under which medical service is furnished and paid for is quite another. Everywhere in the country, and among people in all walks of life, there has developed a consciousness that our present system of private practice of medicine has ceased to serve efficiently or well under our present system of individual purchase of medical service. Medical science and the healing art has become an enormously complicated matter, but the system of medical practice still rests on individual practitioners. The costs of good medical care have become steadily larger and larger, and doctors know less and less about the financial condition of their patients. The individual doctor, however, still has to practice under a fee system that was developed when both medicine and society were vastly simpler. Patients are now served by a complex array of practitioners, hospitals, specialists, laboratories, etc. They still are shuttled around from one to the other with little or no coordination among those who have valuable services to furnish.

The underlying difficulties are of two kinds. There is first the problem of *paying the costs*, including the costs of medical, hospital, nurs-

ing and other care and also the wages lost when the worker is disabled; there is second the problem of *organizing the services.* Both present the need for arrangements that must be worked out by the public and the professions working together closely and cooperatively.

No one needs to tell a family of small means that sickness or its possible coming brings great worries or fears. What people have not known is that there are ways of improving health and sickness services, that there are well-known means of protection against the threat of high sickness costs, and that there are well-established methods of insuring the worker against the possible loss of wages when he cannot work because he is sick and disabled.

There is a growing unrest in the medical, dental, nursing, and other professions. They know all is not well with them or with their work. Even more, there is a greater unrest in the public, and people are searching out the troubles and their causes. They are becoming health conscious; they are more and more concerned each year about their failure to obtain even the minimum essentials of medical care because of the cost of these services. They know that only the well-to-do can afford good care, and—in some of the large cities—only those who are extremely poor or dependent on charity can have the advantages of free care. The great mass of the American people are neither rich nor indigent, and they do not want medical care as a hand-out either from charity and welfare agencies or from the doctor and the hospital.

Members of the profession and the public are learning that the practice of medicine, after centuries of tradition of public service, has fallen into a business world. Since before the Dark Ages, the economic relation of the physician to society was summed up in the phrases: to each according to his need; from each according to his means. And this was a sound and simple rule, easily followed and with justice to all, in the calm and stable local communities of an agricultural world. Unfortunately, this system of relations has come to grief upon the rocks and shoals of a business world. The individual physician often has only brief and fleeting contacts with those he must serve. The admission officer of the hospital, the clinic, or the laboratory does not know the individual patient; the economic or social position of the patient is generally unknown to the practi-

tioner, often is scarcely determinable by the patient himself, and commonly is variable as well as insecure. Moreover, preventive medicine has come into the field and has begun to break down the age-old tradition that the patient must seek out the physician.

Too much cannot be said in praise of the resistance which the real leaders of medicine have offered against commercialization. But something more than resistance has become necessary. Forward-looking action is needed from all who hold that medical science and medical art are of paramount importance to society and must be made more effective in serving the public need.

### *Emergence of Public Health Services*

TO GUARD the health of the people and to protect itself against the burdens which illness may create, society has discovered its stake in health and medical care. Society has rapidly expanded its facilities to bring public health services and preventive medicine to the people; society waits less and less upon the initiative of the individual.

Public health started as an arm of the police power of the state. The purpose was at first to protect one person against the communicable disease of another. Later, its scope was broadened to prevent disease wherever it might occur. No longer was it restricted to the control of communicable disease. Public health had, of necessity, to look to the public water supply, the systems of refuse and sewage disposal, the keeping of vital statistics, the inspection of children in school, the immunization of individuals against disease, and the provision of laboratory services. Safeguarding the public health has required the building of hospitals, the provision of public health nurses, and the creation of public authorities to educate the public in the practice of healthy living. Health centers and welfare stations have been established where services are brought within the reach of the people, where the mother may be taught care of herself and of her infant child, and where scientific birth control may be taught. Public health has come increasingly to recognize the importance of social relations such as the effects of disease and disability upon the life of the family, upon economic well-being, and upon social dependency. The public health has become the public concern and society must guard itself.

All public health work is, in an obvious sense, public medicine. In the modern world, the health of the public is a social concern, even as is the education of the people. In this sense, the socialization of health has long been an accepted doctrine of society, as general as the public acceptance of socialized education, socialized roads and streets, or socialized police or fire protection. Without at least a certain amount of public medicine or state medicine, no modern society can exist. The question which the public must face is not whether it wants "socialized medicine," but how much does it want or how much must it have?

### *Forces Back of Public Medical Care*

WHAT are the forces which are urging us along the path of socialized medicine? First, there is the constant pressure to conserve public health better than we do now and to protect society against the burdens of mental and physical breakdown; second, under the battering of scientific discoveries, the steady disappearance of the dividing line between prevention and cure; third, the increasing need for more elaborate and more expensive personnel and facilities, beyond the means of the individual practitioner of medicine; and fourth, the increasing need for a more adequate system of paying for medical costs.

There is a common thread in all four. The increasing complexity of public needs and of the nature of good medical service both operate to increase the costs. More and more the advance of medical science and the perfection and complication of medical practice carry medicine beyond the financial reach of millions of people. Only the common action of the members of society and only the common pooling of funds will suffice to bring good health and medical care within the means of the people.

### *Inadequacy of Medical Care*

TODAY medical care is beyond the means of millions of Americans. Why is this? Is it because we have inadequate facilities to furnish medical care? Certainly not; we have nearly enough physicians, dentists, and hospitals, and sufficient specialists, nurses, and pharmacists to provide all the service which medical

judgment says the people need. Approximately 128,000 physicians, 66,000 dentists, 200,000 nurses, 50,000 midwives, and over 60,000 other practitioners are engaged in private practice. One and a half billion dollars are invested in non-governmental hospitals, and these institutions contain one-third of our million hospital beds. Each year we spend for all kinds of medical care about two and a half billion dollars from our private purses. In a rough and inadequate way these figures on personnel, facilities, and costs measure the extent of private practice. In addition, there are public, tax-supported services for which we spend between five and six hundred million dollars a year. Altogether, we have over a million persons making their living out of health and sickness services and we are spending about three and a quarter billion dollars for their services and for the medicines and other commodities they sell.

Do we have inadequate health service because the people are not sufficiently health conscious and are unaware that they need medical care? Certainly not; in no country in the world is the desire for health and the appreciation of medical service greater than in our own.

Is it because we cannot afford good medical care? Certainly not; in any year we spend about $3,200,000,000 for health and medical services, and this is nearly enough to buy adequate medical care for everyone.

Then why is it that in an average year about one-half of the people receive no services from a physician, four-fifths get no attention from a dentist, five-sixths receive no health examination or similar preventive service, less than four percent of all adult persons receive an examination of any sort, and four out of ten receive absolutely no medical, dental, or eye care of any kind? Why is it that neither the rich nor the poor, and certainly not the great middle class, receive anything even approaching adequate medical care? Why is it that the proportion of serious illnesses which go unattended is more than three times as great among the poor as among the well-to-do?

The conditions summarized in these statements may seem to exaggerate the facts. It may be explained that they are based on the unchallenged findings of the Committee on the Costs of Medical Care which spent five years (1927-1932) studying the situation and which collected the most comprehensive information ever brought together,

in any country, on this subject. These findings are quoted because they are probably the most moderate—and not because they are the most extreme. They are moderate because they apply to prosperous years.

More recent surveys conducted by the United States Public Health Service and by other trustworthy agencies paint a much darker picture. The National Health Inventory, recently completed by the Public Health Service, reaches the following conclusions:

"Not only do relief and low income families experience more frequent illness than their more fortunate neighbors but their illnesses are of longer duration. This duration of disabling chronic illness among the relief families was 63 percent longer than it was in the group with $3,000 and over.

"Coupled with the higher frequency of illness in this relief group this gives rise to an annual per capita volume of disability within the group that is three times as great as among the upper income families, twelve days as compared with four days per person.

"Also, the non-relief group with an income under $1,000 showed a volume of disability over twice that in the highest income group; the families, with incomes between $1,000 and $2,000 showed a 20 percent excess. . . .

"The survey indicates clearly to what extent this preponderance of illness among the lower economic groups is cared for or neglected under the headings (1) attendance by a physician, (2) nursing care (visiting and private) and (3) hospital care—all in relation to family income.

"In this same eighty-one-city survey comprising over two and a quarter million persons, the proportion of cases of disabling illnesses receiving no care from a physician was 17 percent for families with incomes of $3,000 and over, but was 30 percent among relief families and 28 percent for non-relief families with incomes under $1,000.

"But a more marked deficiency is indicated when the comparison is made on the basis of the volume of service received per case of disabling illness (attended and not attended).

"In a surveyed population of over a quarter million persons in eight large cities, the average case of disabling illness in families with incomes of $3,000 and over received 5.7 calls from a physician, compared to only 3.9 calls per case among families on relief.

"This represents the upper-income families as receiving 46 percent

more service per illness than the individuals in the lower economic brackets."

Further light on recent health conditions is thrown by the reports of the Technical Committee on Medical Care to the National Health Conference, July 18-20, 1938. This sub-committee of the United States Government included experts from the Public Health Service, the Children's Bureau, and the Social Security Board, having at its disposal all the pertinent information that could be gathered in the country.

"While sickness among the poor is more frequent in occurrence, and of greater severity, than among families in the upper economic groups, numerous surveys indicate that, notwithstanding their greater need, the poor obtain less medical care than the well-to-do. For example, a study made in the last prosperous years before the depression set in showed that well-to-do sick persons received nearly three times as many services from physicians, six times as many in each 100 received dental care, two and one-half times as many had health examinations as did self-sustaining families with incomes under $1,200 a year. The proportion who went through a year of life without professional care was more than three times as high among the poorest as among the wealthiest families—despite services furnished to those in the lower income class without charge. The amount of general hospital care (per capita) received by low income families in this survey was approximately the same as that received by families in the highest income class. Surgical operations, however, were almost twice as frequent among persons in the well-to-do group as among the poor."

The committee cited the results of the National Health Survey on the inadequacy of medical services received by the medically needy in 1935:

> "Hospital care in the large cities, in terms of the proportion of illnesses hospitalized, was approximately the same in amount among rich and poor, a fact explained by the relatively large supply of hospital beds supported by public funds in the metropolitan areas. In the smaller cities in which hospital facilities are less adequate, the rich maintained the proportion of hospitalized illnesses at the level of the metropolitan centers, but among relief and marginal income families, the proportion declined progressively with city-size.
>
> "*Medical care in the home, clinic or physician's office* however is the type of service adaptable to the requirements of the ma-

jority of illnesses. Among relief and marginal income families, both the proportion of illnesses receiving such care, and the average number of consultations per case, were consistently lower than among families in comfortable circumstances in all parts of the country. Although the proportion of hospitalized illnesses among these low income families in the small cities was markedly lower than in the metropolitan areas, no compensating increase was observed in the proportion of cases receiving extra-hospital medical care.

"*Clinic supervision* provides adequate medical care for certain ambulatory cases of illness, but the concentration of out-patient facilities in the large cities greatly restricts the benefits of these services. Clinic care was received by 15 percent of illnesses of the canvassed relief population in the metropolitan centers, but in the small cities under 25,000 population, 2 percent, and in the rural areas, only 0.2 percent of illnesses in relief families received clinic care. While the proportion of illnesses in the relief and marginal income groups was approximately the same, 54 percent of all cases receiving clinic care were in relief families and only 19 percent in the marginal income group.

"*Bedside nursing care* by a private duty nurse was received by only a small proportion of illnesses in relief families—less than one percent, compared with seven percent among families in comfortable circumstances. Bedside nursing care provided by visiting nurses was relatively frequent in the relief group of the large cities, reaching 13 percent of the cases, in cities of less than 100,000 population, the proportion was somewhat lower, the figure being nine percent. In the rural areas, only two percent of illnesses received visiting nursing care—approximately one-fourth of the average for the large cities. As in the case of clinic care, a much larger proportion of visiting nurse service was absorbed by the relief groups than by the marginal income class.

"*Dental care* is notably inadequate among low income families. In one of the large cities canvassed in the National Health Survey, information was obtained on the receipt of dental care. In families of skilled, semi-skilled, and unskilled workmen, the proportion of adults who had never received dental care was almost twice as high as in the families of white collar workers. In a recent survey of families in California cities, the proportion of persons requiring, but not receiving dental treatment was four times as high in families of the lowest income class as among the well-to-do."

The inadequacy of medical care among the poor assumed greater significance, the Technical Committee on Medical Care reported, when certain groups of the population or certain diseases were considered. Thus, the disparity in medical attendance of illness of children under 15 years of age at various income levels was found to be even greater than among adults. Apparent in all areas, this was particularly marked in the south. In small southern cities about one-sixth of the deliveries to white women, and almost half the deliveries to Negro women, in families with an annual income below $1,000, took place with no physician in attendance. Among the aged whose illness required a physician's services, those in families of comfortable circumstances received almost twice as much care on the average, exclusive of hospital treatment, as did those on relief.

Southern Negroes in the relief and marginal income groups who suffered from tuberculosis stayed in the hospital 94 days, on the average, whereas whites in the same income class averaged 159 days in the south and 174 days in the northeast. In large cities the proportion of cases of certain chronic diseases—cancer, rheumatism, diabetes, the cardio-vascular-renal diseases—receiving hospital care was about the same among rich and poor, though higher for relief families than for the marginal income group. In small cities, except in the east, the proportion of these chronic cases among the low income groups receiving hospital care dropped sharply, because of inadequate hospital facilities, but families in comfortable circumstances maintained about the same proportion as in large cities.

Even the well-to-do, however, do not receive the care that professional opinion considers necessary. A recent study of families with annual income between $5,000 and $10,000 showed that they received only two-thirds as many services from physicians, only three-fifths as many days of general hospital care, and less than half the dental care required by professional standards.

The Technical Committee concludes:

"Studies of this kind do not show merely a special contrast between the poor at one extreme and the wealthy at the other. On the contrary, they show a more or less regular gradation from the lowest to the highest income groups. The large majority of the population which falls between the income extremes shows the same phenomenon;

they receive medical care not according to their need but according to their income level. For an overwhelming majority of the entire population and for an even larger proportion of self-supporting persons, medical care must be purchased privately, and the frequency of purchase depends largely upon the purchase price."

### *Uneven Burden of Medical Costs*

"Why do self-sustaining people with low incomes receive inadequate care?" the Committee asks. "The first basic reason is found in the irregular and unpredictable occurrence of illness and of sickness costs.

"Families spend, on the average, four to five percent of income for medical care, the proportion being fairly constant up to an annual family income of $5,000, beyond which it tends to decline slightly. These average figures do not, however, give a realistic picture of the burden created by medical costs. The need for medical care by a family is uneven and unpredictable. In one year, little medical service or none may be required; in another year, the family may suffer one or more severe illnesses among its members and may require medical service costing large amounts. No particular family knows any month or any year whether it will be among the fortunate or among the unfortunate. When serious illness comes, it may bring large costs and may descend with catastrophic force on the current budget, on savings, on freedom from debt, or the economic independence of the family. Every substantial study of medical costs shows that they are burdensome more because of their uncertainty and variability than because of the average amount. And this is equally true for the urban family of the industrial wage earner and for the rural family of the farmer or farm laborer.

"Nor do the statistics of actual family expenditures tell the whole story. Knowing in advance that they cannot pay large medical bills, many families ask for 'free' care, and many go without medical attention. Nor is it difficult to picture the distress of those families which incur large bills and undertake to pay them. In one case or another, the savings of a lifetime may be wiped out, the hopes and dreams for a home or farm thwarted, educational opportunities sacrificed, the family deprived of those things which make life pleasant and living worthwhile. Nor do the statistics leave any doubt why physicians and hospitals have difficulty in collecting their bills. Is all this necessary or inevitable? Is there no remedy? Is our system of providing, buying, or paying for medical care the best that can be devised to meet our present needs?

"The burden of sickness costs is mitigated in some measure by the

arrangements whereby fees are adjusted to ability to pay. But the sliding scale operates only in limited ways and is open to very serious abuses. Though free and part-pay services and facilities have been extensively developed, especially in the large cities, though physicians give generously of their services, and though governments have greatly increased tax support for services furnished to the poor, the fact remains that large costs still fall on small purses."

### *Medical Need and Ability to Pay for Adequate Care*

THE uneven burden of medical costs is one cause of inadequate care, the Committee found, and there is also another cause of great importance. A considerable proportion of the population cannot afford to pay the full cost of adequate care. The increasing cost of good care has created a class of people who are self-supporting and independent for all their other basic needs, but who cannot afford the costs of necessary medical care.

An increase in average family income cannot solve the problem created by the irregular incidence of illness and of medical costs. If every person's income were somehow doubled, the problem of paying for medical care would be alleviated somewhat, but it would not be solved. Recent studies, the Committee continued, provide a basis for estimating the cost of adequate medical care as defined by competent professional judgment.

"*If purchased on an individual basis for minimum fees,* such care (exclusive of the costs of community services, dentistry, medicines, or appliances) would cost, on the average, about $76 per person a year or about $310 for a family of average size. Obviously such expenditures for medical care would be possible for the great majority of all families only with extraordinary adjustments in the distribution of income, in budgets, and in standards of living.

"Alternatively, the cost of adequate care may be estimated crudely on *the assumption that care is purchased by groups* rather than by individuals. From the experiences of various organized medical service and insurance plans, about $17.50 per person a year appears to be a reasonable minimum estimate of the cost of furnishing adequate care, exclusive of dentistry. Adequate dental care would cost at least an additional $7.50 per person a year. This gives $25 per person or $100 for a family of four as an estimated minimum cost of adequate

care purchased *collectively by groups rather than by individuals.* Expenditures of this amount would mean approximately doubling the average sum spent by families at the $1,000 income level, adding one-third for families with $1,500 a year and one-fifth for families with $2,000 a year. Families with $2,000 a year or less represent, in different years, about 60-80 percent of all the families of the nation. Self-sustaining families with less than $1,000 a year and those whose incomes must be supplemented would have to be aided even more. Families with incomes of $3,000 and more spend more than $100 a year on medical care.

"The conclusion is inescapable that considerable proportions of the nation's families are too poor to afford the cost of adequate medical care from their own resources. If they are to receive such care, some part of the cost must be borne by the more prosperous. This is not a new principle; it has long been practiced in the payment for medical care, and the medical profession has always insisted that people should pay for medical care in proportion to ability to pay.

"Sickness has become a hazard like death or unemployment in that it entails losses which may be greater than the individual can meet unaided from his own resources. The need for food, shelter, and clothing can be budgeted by the individual family; sickness costs can be budgeted only by a large group. *If medical care is to be made available to all families with small or modest incomes at costs they can afford, the costs must be spread among groups of people and over periods of time.* Some arrangement must be worked out whereby individuals will make regular periodic contributions into a common fund out of which the costs of medical care will be defrayed for those who are sick. Thus, in each year, the majority who require little or no medical care will help pay the bills of the minority who happen to need much medical care. One year, some will be the fortunate ones, will have small sickness needs, and another year they may be among the unfortunate and so need the help of others."

There are problems of public ignorance, of uneven geographical distribution of practitioners and hospitals, of excessive specialization in the professions, of wasteful expenditures on patent medicines and nostrums and on quacks and charlatans. But the basic problem is this: For the family of moderate or less than moderate means, the costs of medical care are incurred in a haphazard and uncertain way. These families cannot budget these costs in the same way in which they budget the costs of food, clothing, or rent. The underlying cause is the individual fee-for-service purchase of medical service.

### *Income of Physicians and Hospitals*

The uneven burden of medical costs upon individuals and families has its counterpart in the uneven distribution of income among the physicians, dentists, and nurses who minister to them. Even in the peak year of prosperity, 1929, for every physician who earned more than $10,000 as an annual net income from his professional practice, there were two who earned less than $2,500. For every dentist who earned more than $10,000, there were four who earned less than $2,500. Since then, the economic status of doctors, dentists, and nurses has been much worse.

Inadequacies in the receipt of medical care are reflected in inadequacies in the incomes of the practitioners and hospitals. While doctors are only partly occupied, while nurses suffer from substantial unemployment, and while hospital beds stand empty, millions of persons in need of service do not receive it.

It is significant to record the fact that every sound arrangement to reduce the burdens of the public created by variable sickness costs operates to stabilize and increase the incomes of those who furnish the services.

### *Averaging the Costs of Medical Care*

Most of the problems of medical costs disappear when we speak in terms of averages. We spend in the United States, for all kinds of health and medical care, $19 to $20 per person from our private purses. If each family had to budget only the average costs for its income class, several important consequences would follow: It could afford to spend more for medical care than it ordinarily spends, just as it can for other commodities or services which it purchases on a budgeted or installment basis; practitioners and institutions could earn larger, more stable, and more assured incomes; the volume of medical care would increase; unattended illness would almost disappear. Averaging the costs means distributing the costs among groups of people and over periods of time. This is equivalent to applying the insurance principle. Averaging the costs substitutes a uniform and predictable average cost for a variable and uncertain individual cost. People of small or moderate means can-

not individually budget medical costs. But they can budget medical costs on the basis of large groups, just as they do for life insurance or fire insurance or other kinds of insurance.

The greatest and most urgent need to bring health and medical service to the people and to assure reasonable incomes to practitioners and hospitals is a system of insurance or group budgeting against medical costs. This would require a subsidy for the lowest income groups and for those who have no income, but we are already paying such subsidies and must continue to pay them.

### *The Insurance Proposal*

THERE is nothing new in an insurance proposal. In the United States, more than in any other country of the world, we believe in and practice insurance. We insure our houses and automobiles against fire, burglary, or injury; we insure life and limb; we insure against industrial accidents and occupational disease; we insure against old age and dependency; we have even begun to insure against unemployment. Nor is there anything new in insurance against illness and the need for medical care. Group budgeting for medical service is practiced in the United States in hundreds or thousands of communities where voluntary organizations have developed in response to local needs. Insurance against medical costs is not a new-fangled invention; it goes back in this country to the pioneering days of the mines, railroads, and lumber camps.

Lately, under the leadership of the American Hospital Association, we have been learning how to practice the group budgeting of hospital costs. Group hospitalization plans are in actual operation in about thirty States and in forty or fifty cities. Between fifty and a hundred more local plans are in process of development. There are nearly 2,000,000 persons covered by non-profit group hospitalization plans, and the number is increasing daily.

Group budgeting for the service of a physician has also made a beginning in this country, often on an inadequate financial basis, in hundreds of fraternal orders and industrial groups. In California, Oregon, and Washington important insurance medical-service plans have gone forward under the auspices of the State and county med-

ical societies. The principle of insurance for medical costs has also been approved—in one form or another—by a number of state and local medical societies, and other representatives of organized medicine. Hundreds of industrial medical-service plans—whether company plans or employee mutual benefit associations—operate medical-care insurance.

Some forty countries of the world have health—or sickness—insurance systems, twenty-two being entirely on a compulsory basis and the others involving legal or economic compulsion in greater or lesser degree. In Great Britain, in addition to the fact that sixteen million persons are included in the compulsory system of insurance which covers only the services of the general practitioner of medicine and prescribed medicines, at least ten million persons voluntarily insure for hospital care. The lessons from this experience are available to us.

### *The Federal Government's First Proposal*

A few years ago, when President Roosevelt introduced his social security program, many health experts were of the opinion that these lessons of successful experience in health insurance at home and abroad had been driven home so vigorously that the President and the nation's legislators would soon be found pressing for a practicable system of health insurance. In transmitting to Congress the report of his Committee on Economic Security on January 17, 1935, the President said, "I am not at this time recommending the adoption of so-called health insurance, although groups representing the medical profession are cooperating with the Federal government in the further study of the subject, and definite progress is being made."

In that report, the Committee on Economic Security said, "As a first measure for meeting the very serious problem of sickness in families with low income, we recommend a nation-wide preventive public-health program," to be "financed by state and local governments and administered by state and local health departments, the Federal government to contribute financial and technical aid." The Committee then went on to say, "*The second major step we believe to be the application of the principles of insurance to this problem.*"

The Committee informed the President that it had enlisted the co-operation of advisory groups representing the medical and dental professions, nursing, and hospital management in developing "a plan for health insurance which," it said, "will be beneficial alike to the public and the professions concerned." These advisory groups had, the Committee stated, requested an extension of time "for the further consideration of these tentative proposals, and such an extension has been granted to March 1, 1935." The President was further informed that the Committee had effected arrangements for a close co-operative study between its technical staff and the technical experts of the American Medical Association. It is very significant that the setting up by the President's Committee on Economic Security of its professional advisory committee marked the first time in the history of social insurance that a government called in the professions concerned with health insurance at the beginning to help formulate an official program.

### *British Physicians and Health Insurance*

In Great Britain, a quarter of a century ago, hardly consulting the medical profession, Lloyd George put the National Health Insurance Act through Parliament while the doctors remained aloof or in opposition until the eleventh hour. Today it is very difficult to find a physician in Great Britain who is not making at least a decent living or one who would consider for a moment abandoning health insurance, the Journal of the American Medical Association and other American medical journals to the contrary notwithstanding. Indeed, the British Medical Association and the local insurance committees of doctors throughout the country have gone on record over and over again for extension of the benefits of National Health Insurance to embrace not only the workingman but all members of his family as well, and also to extend the medical benefits to include hospitalization and the services of various specialists.

Witness the following quotations from a statement by Dr. G. C. Anderson, Medical Secretary of the British Medical Association:

"Soon or late, I predict, every modern civilized community must acknowledge its duty to make provision for the health of its members

if they cannot secure it for themselves. In America and elsewhere, there are large numbers who suffer from this disability.

"I think that, after twenty-two years, we may be said to have passed the experimental stage in Great Britain and are able to evaluate the merits and defects of our health insurance plan. That it has some defects may be freely admitted, but they are emphatically not those which the American Medical Association has thrust into the foreground.

"Chiefly, the American Medical Association and its members who oppose national health insurance allege that it has proved to be a failure and detrimental to the interests of both profession and public. It is said that the so-called "panel system" has tended to stifle initiative and reduce all professional service to the same level of mediocrity.

"Nothing could be farther from the truth. . . . As a matter of fact most of our physicians are eager for panel service. . . . Without such a steady income many would have found it difficult to earn a living by the exercise of their profession alone."

Continuing, Dr. Anderson says:

"From the viewpoint of the public, the insurance act has been equally successful and any attempt to represent it as being otherwise proceeds from a misapprehension of the facts. . . . The benefits of the scheme are evident to the public and the public pays its share cheerfully."*

### *The American Medical Association Lobbies*

As stated above, in the formulation of a national health insurance plan, the United States is the only country in which the professions were let in on the ground floor. Here they were invited and urged to participate in the formulation of the plans. The President's Committee on Economic Security delayed its final report to give the doctors, the dentists, the hospital administrators, the nurses, and the public health authorities not only every opportunity to be heard but every facility for criticism and suggestion concerning the program under consideration. How did they utilize their opportunity? The dentists helped; the hospital people helped; the nurses helped; and the public health people helped. Each gave intelligent and critical advice and counsel. But the doctors "co-operated" with the President's Committee with a technique which has its own

*Chicago Daily Tribune, Oct. 11, 1936.

unique effrontery. While certain of their leaders and officers were in the full confidence of the official studies which were still in progress, and while the President's Committee and its staff were still deliberating, the American Medical Association held a special session of its House of Delegates—the first since the World War—and passed resolutions condemning compulsory health insurance! There were members of the Medical Advisory Board, be it said to their credit, who were independent of this action and were not party to this political trickery.

The American Medical Association has been exerting all its power to prevent compulsory health insurance from taking its proper place in the Social Security Act. So-called "organized medicine" is using every device known to pressure groups and politicians to prejudice the country against a comprehensive national health program, and particularly against compulsory health insurance. The American Medical Association and its satellite societies have printed in their medical journals false and misleading statements concerning the operation of health insurance in England and other European countries. And this campaign of misinformation still continues. They have passed resolutions based strictly on selfishness and their vested interests. Like ordinary lobby groups, while the Economic Security Bill was pending, they saw to it that thousands of telegrams were sent to the President and to the Congress, seeking to exert pressure without reference to the merits of the proposals under consideration; they used personal influence on those in high places; they spent tens of thousands of dollars in publicity campaigns of misinformation; they spread false rumors and resorted to scurvy attacks on individuals. They even pulled the purse strings of reputable research agencies in an effort to curb the freedom of speech of their opponents on the staffs of such organizations.

### *The American Foundation Speaks*

People wondered how long the real leaders of the medical profession, and the rank and file of the various auxiliary professions—dentists, nurses, hospitals, and others—would permit the medical politicians, who too often control medical societies and

the editorial columns of their Journals, to continue to obstruct progress and to delay and forestall sound legislation. A ray of hope recently began to shine over the horizon of organized medicine, emanating from a massive two-volume report issued in April, 1937, by the American Foundation, entitled *American Medicine: Expert Testimony Out of Court.* Most strikingly it presents the doctor's dilemma in the testimony of 2,100 representative leaders in every branch of American medicine from every State in the Union, most of them in practice twenty years or more.

The consensus of opinion of the American men of medicine who are credited with the authorship of these volumes is clearly that the doctor "is no longer concerned exclusively with the care of the sick, but also with a guardianship of the health of the nominally well," that "the present costs of medical care are tragically out of reach of a large part of the population"—that the State has a stake in the health of its people. This is progress, and much of it is quite obviously contrary to the official views of the American Medical Association. Keep in mind that the authors of this report, with apparently few exceptions, are members in good standing of the Association.

The *New York Times,* commenting editorially on this report of the American Foundation, said:

"Not social workers despised by the American Medical Association but doctors themselves, a veritable 'Who's Who in Medicine,' wrote the Foundation's report. . . . It is now doubtful if the entrenched officers of the Association truly speak for organized medicine. The 2,000 representative physicians demand far-reaching, socially-conceived reforms in medical education and practice because 'the best is not yet good enough.' But the Association through its journal advocates a policy of letting medicine evolve naturally (while millions lie ill without adequate care or die because it costs too much to have a doctor) and regards the practice of medicine as a vested interest akin to that of a plumbers' union in the installation of bathtubs or kitchen fixtures. On many a page the Foundation's report refutes a Bourbonism which holds that all's well with the general practitioner, that medical care is adequate on the whole. . . . If, as the Foundation makes it clear, the practice of medicine needs continual revision in the light of new community needs it is evident that social and economic changes cannot be ignored. Yet the American Medical Association would have us believe that the old laissez faire evolution is good enough today because it was supposedly good enough yesterday."

## *The Committee of Physicians*

HARD on the heels of the American Foundation's report there came into being early in November, 1937, a professional group, popularly known as "the 430" because it originally consisted of 430 physicians who organized themselves into a committee and who subscribed to the following principles:

"1. That the health of the people is a direct concern of the government.

"2. That a national public health policy directed toward all groups of the population should be formulated.

"3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches to their solution.

"4. That in the provision of adequate medical care for the population four agencies are concerned; voluntary agencies, local, State and Federal Governments."

"The Committee of Physicians" (its membership since increased from the original 430 to over 800), including leading physicians from every part of the country and all branches of medicine, has taken aggressive leadership against the entrenched officers of the American Medical Association and is challenging the Association's defense of the *status quo.* This Committee is asking for no revolution in medicine; it is asking only for free speech within the profession on subjects of fundamental concern not only to every doctor but to every citizen.

In light of the actions recently taken by the American Medical Association (Sept. 16-17, 1938) endorsing most of the program submitted by the President's Interdepartmental Committee to the National Health Conference, a new opportunity has been provided for physicians to cooperate with government and other public groups in advancing the nation's health. It remains to be seen whether "the 430" and other medical leaders, members in good standing of the American Medical Association, will take an aggressive position in the ranks of organized medicine, or whether they will continue to permit themselves to be represented (and misrepresented) by officers and editors who obviously do not speak for them and who are today the

chief, if not the only, real obstacle in the way of realization of a comprehensive national health program.

It remains also to be seen whether progressive citizens of America will continue to be intimidated and to remain almost inactive in the face of selfish opposition to health measures which promise to deal with an underlying cause of poverty and dependency. How can progressive people expect the President and the Congress to act on a controversial issue, in the face of such vociferous and politically powerful opposition to health insurance, if there is no organized expression of public opinion in favor of it?

### *Some Practical Questions in Health Insurance*

When the practical problem of adopting a system of health insurance is tackled, the American people will be asked to consider carefully what constitutes a desirable system of insurance for the United States. I present here, not as definite proposals but only as a basis for constructive discussion, some tentative conclusions reached from studies by my former associates and myself.

1. *Which fractions of the population should be covered by the plan?* In Europe and in America it has been customary to restrict health or sickness insurance to those who earn small wages, generally less than $1,200. All European and practically all voluntary systems are poor-man systems, and are geared to the financial resources of the poor. Only by carrying a large panel of patients can the physician earn a decent income in a poor-man's system. Physicians and other practitioners in America who indorse insurance against medical costs only for the lower-income brackets fail to realize that they spite both themselves and the public.

Our primary problem is not how to furnish financial assistance to the poor—though the problem of medical care for the poor is a pressing one—, but to enable those who cannot buy medical care as individuals to buy it as groups. The costs of medical care cannot be budgeted individually by families whose incomes are less than $3,000 or possibly $5,000. Sickness insurance, therefore, should apply to all families with annual incomes of less than $3,000 or $5,000, and pre-

ferably should permit insurance of all persons and all families in the population. We want no poor-man's system in America.

It is clearly desirable to coordinate an insurance program with other official and voluntary health and medical activities. The necessity for some support from tax funds to pay the contributions of those who have no incomes, and to pay for services already being provided out of tax funds, leads us to the conclusion that an insurance system should be organized on a State-wide basis. It should absorb the poor and the needy through contributions on their behalf by the public responsible for their support. A "means test" would then be needed to decide which people need public assistance, not which people need free medical care.

2. *Should the plan be voluntary or compulsory?* European experience shows clearly that every voluntary scheme is merely a shorter or longer bridge to a compulsory scheme. Experience is accumulated through voluntary insurance, and this is very useful in the establishment of a compulsory system. Unfortunately, however, many of the worst abuses which develop under voluntary schemes are carried over into the compulsory stage and remain to confuse the new administration and to interfere with efficient operation.

The people in the lower-income brackets, who most urgently need an insurance plan, show the greatest inertia in coming into a voluntary plan. The poor, the mass of workers, can be only partly, if at all, covered by voluntary insurance, and our society has no protection against the burdens which they carry and create. If insurance is to cover the people whom it should, it must be grounded on a compulsory basis.

3. *What medical services should be furnished?* Medical benefits in an insurance program should be divided into two classes. The first should include services of the general practitioner and hospital care. These services should be mandatory upon the system and available to all insured persons. The second class might include other medical service, such as those of the medical specialist, dentistry, home-nursing, laboratory and clinic service, home remedies, and medical commodities. These might be made permissive for each community which desires such services, which has the means to pay for them and the facilities to furnish them, and whose plan receives the approval of the

proper insurance authority. It is conceivable that even the second class might be made mandatory as rapidly as the personnel and facilities become available.

Cash benefits should also be furnished to the sick to replace partially wages lost on account of illness. This principle is generally accepted by proponents of health insurance, although some urge that such benefits should be furnished through another branch of the social insurance system.

4. *How shall practitioners and institutions be remunerated?* It is possible for a system of compulsory insurance of the kind outlined above to keep the costs of medical service within the means of the public and yet pay the practitioner a fair return for his service—a more adequate remuneration than most physicians now receive. Just how he is to be paid can be determined by the organized group of practitioners in each local area; they can be permitted to choose a system based upon salaries or annual fees per person, or fees per unit of service. Whatever the actual procedure by which the physician is remunerated, the general practitioner can be paid a sum that would leave him with a better net income from his insurance practice alone than he ordinarily earns, apart from what he may earn from his non-insurance practice.*

Experience shows that the costs of hospital care can be adequately met from an insurance fund for a reasonable cost. In principle, all that is needed is an arrangement whereby a non-profit insurance fund agrees to remunerate each approved hospital at a fixed sum for each patient-day of service rendered to insured persons. The insurance risk is carried by the insurance fund, not by the hospital. Such arrangements can be proposed whether the hospitals are owned by governments, by non-profit corporations, or by private individuals.

Similarly, it is possible to face each question on its merits to work out a plan so that each additional type of medical practitioner or institution may be adequately remunerated at a cost within the means of the system, and through such arrangements as are mutually satisfactory to the public and to the medical agencies.

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*See I. S. Falk, "Security Against Sickness," and Final Report of the Committee on the Costs of Medical Care.

5. *What would be the total costs of the medical benefits?* For health and medical services, furnished in adequate volume and of high quality, the annual cost would be about $30-$36 per person. This includes not only the services of the general practitioner, the medical specialist, the dentist, the graduate and the practical nurse, the general and special hospital, drugs and medicines, laboratory, etc., but also the cost of adequate tuberculous and mental-disease hospitalization, all desirable forms of public health work, the costs of administration and of a contingent reserve.

The medical services of the kinds which are ordinarily purchased privately would cost about $25 per person. The customary expenditure is probably now about $19-$20 for similar services, but my conception of medical service calls for larger volumes of medical care than either the rich or the poor ordinarily receive. In our tentative budget, certain types of excessive and wasteful expenditures have been reduced and the savings have been applied to more useful services.

The basic problem is not to find more money than is now spent by the nation as a whole, but to find new and better ways of directing customary expenditures into more productive channels. Any community which might adopt less than the complete program would, of course, have proportionately smaller costs. A sound plan providing minimum essential services can be set up for a total annual cost of $20 per person.

6. *How shall the funds be raised?* In the United States in general it has long been customary for approximately 14-16 percent of the costs of health and medical care to be financed through tax funds. In our proposals, services of the kinds ordinarily financed from tax funds account for 20 percent of the budget. We may therefore assume that at least this much might continue to come from tax funds under an insurance program. How should we distribute the remaining 80 percent? Some might argue that all of it should come through taxation which places the burdens upon various groups in the population. Others will contend that the 80 percent should be raised through direct contributions of the insured persons. Some will argue for con-

tributions shared between employed persons and their employers. In every case tradition and practical considerations agree that the costs must be distributed according to ability to pay. Would it not be reasonable to divide the costs among tax funds, employers, and the insured persons?

7. *How should a health insurance program be administered?* In any administrative arrangement that may be devised in a state, it seems essential that provision should be made for public supervision of financial and executive problems and for professional supervision of professional personnel and professional problems. Studies of European and other health-insurance systems show that three types of agencies, closely coordinated, should be provided: executive agencies to set up and administer the plan; a professional agency to care for the problems of professional education and investigation and to administer professional service; and a judicial agency, combining lay and professional members, to deal with complaints and grievances.

Such an administrative plan would recognize that certain basic services should be made mandatory for all insured persons in the state and that the scope of additional medical services should be determined by local needs, local ability to pay the costs, local availability of facilities, and local initiative in formulating a program. Perhaps such a program lays too much responsibility upon local—as distinguished from state—authority. The point requires further study.

European plans for health insurance, excepting the Soviet Union, have never dealt adequately with preventive care. It seems essential that an American plan should place adequate emphasis upon the prevention of disease. It is my opinion that periodic physical examinations of all insured persons by their physicians, immunizations, prenatal and postnatal care, and all other sound and necessary public health services should be required. And it would include arrangements for special payments or bonuses for the preventive services which are furnished by private practitioners. In respect to health care for large groups or for entire communities, an American plan should provide coordination between the insurance system and all other agencies devoted to the prevention of disease.

### *Removal of the Economic Barrier*

THE essence of my proposal is that the economic barrier between the individual who needs care and the practitioner who is prepared to furnish it is removed. Competition for patients between practitioners, between institutions, and between practitioners and institutions is retained; but competition would depend upon the quality and attractiveness of service, not upon the size of a fee. On the broad and unassailable ground that health is the basis of a people's well-being, all who are insured would have opportunity to receive care according to their need, not according to their means. The burden of uncertain and unbudgetable costs would be removed from the individual and would be replaced by the average cost for a group. The uncertainty and inadequacy of professional or institutional income would be replaced by assured, stable, and reasonably adequate return for service. "Free care" would cease to exist for the practitioner or the hospital; excessive specialization would be brought under control; and the quality of medical practice could be raised more uniformly than it is now to a level which is worthy of modern medical service.

The administration of such a system as I contemplate should be guided by five practical lessons which emerge from the study of European and American experiences: (1) freedom of all competent practitioners who subscribe to necessary rules of procedure to engage in insurance practice; (2) freedom of all persons to choose their physician or dentist from among all practitioners in the community who engage in insurance practice; (3) freedom of insurance practitioners to accept or reject patients; (4) no interference of the insurance system with the private purchase of medical service by those persons who prefer and can afford it; (5) professional control of professional personnel and procedures.

### *Other Health Services*

IT GOES without saying that compulsory health insurance is not an alternative to expansion of Federal, State, and local public health facilities unless such expansion is intended to be broad enough to become a substantial public medical service. We already

have public medicine, notably in the care of the insane, the mental defectives, and the tuberculous. Public medicine is meeting a great need, and, in the main, it is efficiently administered; but it is narrowly limited to serve only particular classes of sick or the indigent poor.

I am in hearty accord with the plan for extension of public health facilities favored by the Surgeon General of the Public Health Service, by most of the leading State and local health authorities, and by many voluntary health agencies. We need more and better equipped health centers; more clinics for specific preventive functions; more centers for the diagnosis and treatment of tuberculosis and of the venereal diseases; and more maternity centers and baby and child welfare stations and birth-control clinics.

We are making progress both in the direction of public medicine and public health service. But our progress is too slow. We are reaching hundreds of thousands through these facilities and by voluntary health and hospital insurance, group medicine, and contract practice; but we must meet the needs of tens of millions of our fellow-citizens. While we are cogitating wisely, while we are debating cleverly, while we are splitting hairs, tens of thousands are dying from preventable causes and millions are suffering from remediable sickness. I am convinced that we can meet the needs which confront us, and do this within the near future, only through a comprehensive national health program which includes compulsory health insurance, supervised and financially aided by the Federal government.

A national health plan should be flexible enough to permit the several States to decide whether their local conditions require greater or lesser emphasis on public medicine, on the extension of public health facilities, or on health insurance. But Federal aid—financial and technical—should be available to the States equally for all three procedures. Within broad limitations laid down in a Federal statute, the choice of each procedure and the extent to which it is applied should depend upon conditions in each State and should fall within the sphere of state action.

The program outlined in the preceding pages has been laid by me before many groups on numerous occasions during the past five or six years. It is consistent in every major respect with the program submitted by the Technical Committee on Medical Care and the Pres-

ident's Interdepartmental Committee to the National Health Conference, though their proposals also deal with subjects which I have not touched in this analysis. The Technical Committee's recommendations are as follows:

I

a. Expansion of general public health services.
b. Expansion of maternal and child health services.

II

Expansion of hospital facilities.

III

Medical care for the needy and medically needy persons through public medical services.

IV

A general program of medical care for self-sustaining persons through State-wide systems of public medical service or of health insurance, or combinations of the two methods. Provision for the needy and medically needy should be made in such general programs. Recommendation IV, if adopted, makes Recommendation III unnecessary.

V

Insurance against loss of wages during sickness. Temporary disability is to be covered through State-wide systems of temporary-disability compensation; permanent disability is to be covered through provision of invalidity benefits in the Federal old-age insurance system.

This program is to be made effective through Federal grants-in-aid or otherwise. It would cost a great deal of money, but it would cost little if any more than we are already spending, privately as well as publicly, for very inadequate services and protection. The Technical Committee's program is, in my opinion, sound in every important respect and deserves the careful attention and the support of all who have an interest in improvement of the nation's health.

We now spend more than three billion dollars (about $25 per person) for health and medical services; and this is nearly enough to buy adequate medical care for everyone. The basic problem is not to find more money than is now spent for these services, but to find

new and better ways of directing customary expenditures into more productive channels and of reducing the burdens caused by unequal costs.

Let us put our shoulders to the wheel. We can have, as we should have, a comprehensive health program to meet a crying need of the people. It can be sufficiently flexible to meet the different needs of the several States: public health services for all, adapted through different techniques to urban and rural needs; public medical services where these are most appropriate; medical-care contributory insurance for the wage earners and salaried workers, and, for those who cannot themselves pay contributions, public provision of contributions instead of humiliating and ineffectual hand-out medicine; contributory insurance against temporary or permanent loss of earnings from disabling illness; and Federal aid and guidance over all.

The time is ripe for a change from the present chaotic system of medical organization to an integrated health program for the nation that will make medical care available to all the people and bring it within their financial ability to obtain. Marching behind the banners of such a program, the people of America can sound a clarion call for action in a cause worthy of their highest traditions.

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